IN THE CORONERS COURT
OF VICTORIA
AT MELBOURNE

Court Reference: COR 2017 2725

FINDING INTO DEATH WITHOUT INQUEST

Form 38 Rule 60(2)
Section 67 of the Coroners Act 2008

Findings of:	**MICHELLE HODGSON, CORONER**
Deceased:	**TIMOTHY AGHAN**
Date of birth:	28 June 1964
Date of death:	10 June 2017
Cause of death:	1(a) HYPOXIC ISCHAEMIC ENCEPHALOPATHY COMPLICATING TRAUMATIC ASPHYXIA DUE TO EXTERNAL COMPRESSION OF CHEST BY MOTOR VEHICLE
Place of death:	Royal Melbourne Hospital, 300 Gratton Street, Parkville, Victoria

HER HONOUR:

Background

1. Timothy Aghan was born on 28 June 1964. He was 52 years old when he died on 10 June 2017 after a vehicle he was working underneath fell on him.

2. Mr Aghan lived in St Albans with his wife, Mary.

The coronial investigation

3. Mr Aghan's death was reported to the Coroner as it fell within the definition of a reportable death in the *Coroners Act 2008* **(the Act)**. Reportable deaths include deaths that are unexpected, unnatural or violent or result from accident or injury.

4. Coroners independently investigate reportable deaths to find, if possible, identity, medical cause of death and with some exceptions, surrounding circumstances. Surrounding circumstances are limited to events which are sufficiently proximate and causally related to the death. Coroners make findings on the balance of probabilities, not proof beyond reasonable doubt.[1]

5. The law is clear that coroners establish facts; they do not cast blame, or determine criminal or civil liability.

6. Under the Act, coroners also have the important functions of helping to prevent deaths and promoting public health and safety and the administration of justice through the making of comments or recommendations in appropriate cases about any matter connected to the death under investigation.

7. Victoria Police assigned an officer to be the Coroner's Investigator for the investigation into Mr Aghan's death. The Coroner's Investigator investigated the matter on my behalf and submitted a coronial brief of evidence.

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[1] In the coronial jurisdiction facts must be established on the balance of probabilities subject to the principles enunciated in *Briginshaw v Briginshaw* (1938) 60 CLR 336. The effect of this and similar authorities is that coroners should not make adverse findings against, or comments about, individuals unless the evidence provides a comfortable level of satisfaction as to those matters taking into account the consequences of such findings or comments.

8. After considering all the material obtained during the coronial investigation I determined that I had sufficient information to complete my task as coroner and that further investigation was not required.

9. Whilst I have reviewed all the material, I will only refer to that which is directly relevant to my findings or necessary for narrative clarity.

Identity of the deceased

10. Mr Aghan was visually identified by his wife, Mary Aghan, on 10 June 2017. Identity was not in issue and required no further investigation.

Medical cause of death

11. On 13 June 2017, Dr Matthew Lynch, Senior Forensic Pathologist at the Victorian Institute of Forensic Medicine, conducted an external examination of the body of Mr Aghan and reviewed a post mortem computed tomography (CT) scan.

12. Dr Lynch completed a report, dated 13 June 2017, in which he formulated the cause of death as *"1(a) Hypoxic ischaemic encephalopathy complicating traumatic asphyxia due to external compression of chest by motor vehicle"*. I accept Dr Lynch's opinion as to the medical cause of death.

Circumstances in which the death occurred

13. On the morning of 5 June 2017, Mr Aghan worked on his 1998 Holden Commodore station wagon under the carport in his driveway. He positioned the front wheels of his vehicle on two steel ramps, with the front of the vehicle facing the street. The vehicle was placed in 'park' and the handbrake engaged. Mr Aghan did not put anything behind the rear wheels of the vehicle to ensure it could not roll back.

14. Mr Aghan positioned himself on his back under the passenger side sill of the vehicle whilst it was parked on the ramps to undertake work on the transmission.

15. It appears that whilst working under the vehicle, it rolled down the ramps and stopped only when both wheels hit the ground. The sill of the vehicle came to a rest on the upper section of Mr Aghan's torso, which inhibited his ability to breathe normally.

16. At approximately 10.50am, a council worker, Andrew Izard, observed Mr Aghan trapped under the vehicle and heard him yelling for help. Mr Aghan asked him to get the vehicle off him.

17. Mr Aghan's son's girlfriend, Melissa Petrolo, was inside the house at this time. She went outside when she heard shouting. Upon seeing Mr Aghan trapped under the vehicle, she contacted emergency services.

18. Mr Izard returned to his truck to retrieve metal bars in an attempt to lever the vehicle's weight off Mr Aghan. However, he was unable to lift the vehicle with the bars.

19. At this time, a neighbour, Mehmet Mustafa, also heard shouting. Upon observing the scene, he retrieved a jack from his house. He subsequently managed to lift the vehicle and freed Mr Aghan from under the vehicle.

20. Victoria Police and Ambulance Victoria arrived on scene immediately after Mr Aghan was freed. He was subsequently transported to Royal Melbourne Hospital.

21. Mr Aghan was diagnosed with a hypoxic brain injury secondary to an out of hospital cardiac arrest secondary to crush injury. His prognosis was poor. A decision was made to withdraw his life support.

22. On the evening of 9 June 2017, Mr Aghan was extubated. He passed away at 7.20am on 10 June 2017.

23. After examining the scene, Senior Constable Jason Harvey, Coroner's Investigator, found that the ramp under the front right hand side wheel had slipped from under the wheel. It also appeared that the front left hand wheel had rolled down the ramp it was originally on. There were no wheel chocks at the rear of the vehicle. Although the vehicle was placed in 'park' and the handbrake engaged, Senior Constable Harvey found that the handbrake appeared to be loose and not properly engaging the brakes as it should. He stated that there were no contingencies in place to support the weight of the vehicle when the vehicle failed to remain on the ramps.

Findings

Pursuant to section 67(1) of the *Coroners Act 2008* I find as follows:

(a) the identity of the deceased was Timothy Aghan, born 28 June 1964;

(b) Mr Aghan died on 10 June 2017 at Royal Melbourne Hospital, 300 Gratton Street, Parkville, Victoria, from hypoxic ischaemic encephalopathy complicating traumatic asphyxia due to external compression of chest by motor vehicle; and

(c) the death occurred in the circumstances described above.

Comments

Pursuant to section 67(3) of the *Coroners Act 2008*, I make the following comments connected with the death:

1. As part of my investigation, I requested information about Victorian deaths occurring in similar circumstances since 2000.

2. I identified 33 people, including Mr Aghan, who died after being crushed whilst performing maintenance under a vehicle. All of the deceased were male and their ages ranged from 18 to 81 years. Five had used ramps to raise the vehicle and two had used ramps in association with other mechanisms to raise the vehicle. In these seven deaths, the vehicle was either a car or a utility, and the incidents occurred at home.

3. The *Finding into death without inquest into the death of Lloyd Douglas Hill*[2] explored a death that occurred in similar circumstances. In that case, Coroner Audrey Jamieson discussed the Australian Competition and Consumer Commission's (**ACCC**) previous campaign of safety messages targeting people attempting do-it-yourself (**DIY**) tasks, such as working beneath motor vehicles.

4. Coroner Jamieson went on to make comments about other deaths occurring in similar circumstances. It is appropriate to adopt her wording as they readily apply to the circumstances of this case:

[2] Dated 12 September 2016.

The circumstances of these deaths often involve individual factors such as misusing equipment, instituting improvised methods, or inaccurately perceiving or becoming complacent about the associated risks.

5. Her Honour noted in 2011 the ACCC published a research project entitled *Do-it-yourself (DIY) vehicle maintenance* and identified a number of risk management strategies, including:

   (a) making warning labels more prominent so they could not be missed;

   (b) placing safety information prominently alongside equipment specifications, such as lifting capacity, would ensure ease of fining and reading messaging;

   (c) radio advertisements all day Saturday and mainly afternoons on Sunday (the periods that the project found when DIY tasks are mainly attempted); and

   (d) internet and social media ('how to' videos found on YouTube could have safety messaging incorporated).

6. In 2011, Product Safety Australia launched a national DIY vehicle safety campaign. The campaign involved the ACCC working with state and territory fair trading agencies to raise awareness about people's safety when doing DIY mechanic work. The joint initiative aimed to help curb deaths and serious injuries associated with working under a car. The campaign involved a range of resources including postcards, a competition encouraging the sharing of safety information, a short YouTube safety film, and an informative flyer.

7. Coroner Jamieson made a recommendation that the ACCC review the effectiveness of its national DIY vehicle safety campaign and consider further activities to highlight the campaign.

8. Her Honour also made a recommendation that WorkSafe Victoria review its role in raising awareness amongst the Victorian community of important safety precautions for people engaging in DIY motor vehicle repairs.

9. Since then, I understand the ACCC promoted safe DIY vehicle maintenance as part of its 'Safe Summer' campaign during the summer of 2016 and 2017. The ACCC worked with

WorkSafe Victoria to amplify messaging via workplace safety channels, and generated a new brochure/factsheet for distribution.

10. I note that Product Safety Australia currently has safety information, including videos, on their website.[3]

11. Although there appears to have been a decrease in the rate of deaths in the setting of DIY maintenance under cars since the 2011 campaign, deaths are still continuing to occur.

12. I commend the actions of both the ACCC and WorkSafe Victoria in promoting the risks and safety precautions of DIY vehicle maintenance. It may now be time for the national campaign to be once again enlivened.

13. It appears that in this case, Mr Aghan failed to take important safety precautions, such as chocking the wheels of his vehicle to prevent them from rolling. His death was tragic and preventable.

14. Mr Aghan's death is a heart-breaking example of the inherent dangers associated with DIY vehicle repairs and maintenance. It is vital that the dangers are appreciated because death and injury are entirely preventable. The positive effect of safety campaigns in this respect cannot be underestimated.

Recommendations

Pursuant to section 72(2) of the *Coroners Act 2008*, I make the following recommendations connected with the death:

1. With the aim of preventing injuries and similar deaths, I recommend the ACCC consider renewing its national DIY vehicle safety campaign and once again including DIY motor vehicle repairs in their next 'Safe Summer' campaign.

2. I also recommend that WorkSafe Victoria consider once again working with the ACCC to promote safety of DIY motor vehicle repairs.

[3] https://www.productsafety.gov.au/news/under-your-car-diy-vehicle-maintenance, published 22 August 2014, and https://www.productsafety.gov.au/news/diy-safety-beware-of-dangers-to-yourself-and-to-others, published 8 October 2014.

Publication

Given that I have made recommendations, I direct that this finding be published on the internet pursuant to section 73(1A) of the *Coroners Act 2008.*

I convey my sincere condolences to Mr Aghan's family.

I direct that a copy of this finding be provided to the following:

Mary Aghan, Senior Next of Kin

Royal Melbourne Hospital

Australian Competition and Consumer Commission

WorkSafe Victoria

Senior Constable Jason Harvey, Coroner's Investigator, Victoria Police

Signature:

MICHELLE HODGSON
CORONER
Date: 15 November 2018.